

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06975 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06966

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air <u>Abingdon</u> 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Otter Point Road</u>		d. STREET ADDRESS <u>Route #1</u> *****	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>C.</u> Last <u>Addison</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 Jan. 1889</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sawmill-Gas Station, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Addison</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>217-01-3950-A</u>	
17. INFORMANT <u>Hannah E. Addison, Abingdon, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. Disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E. Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. A. n. md.</u>	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>5-17-66</u>	
Address (Street, city, town, or county) <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>20 May 66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens, Bel Air Md.</u>		23d. LOCATION (City, town or county) (State) <u> </u>	
24. FUNERAL DIRECTOR <u>Walter W. ...</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. DATE <u>MAY 19 1966</u>	

068375

Harford
Baltimore
O'Donnell Road

Harford
Baltimore
O'Donnell Road

Charles C. Addison

May 17

Jan. 1989

Laborer (Rec.) Sewall-Case Section, Maryland

Theodore Addison

517-91-1051-A

Arthur E. D. Davis

James E. Palmer
6-14-89

BOA
2-17-89

Partial SO May 00
Testing Bureau
Washington, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06967

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u> c. LENGTH OF STAY IN 1b <u>DOA.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u> d. STREET ADDRESS <u>632 CHAPEL TERRACE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM PAUL ANDERSON</u> First Middle Last 4. DATE OF DEATH <u>MAY 16 1966</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAR 13 1925</u> 9. AGE (In years last birthday) <u>41</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Edgewood Road</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Phila. Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Anderson</u> 14. MOTHER'S MAIDEN NAME <u>Martha Offner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>233-34-5782</u> 17. INFORMANT <u>Mr. Edith C. Anderson</u> Address <u>632 Chapel Terrace Harford Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO (b) <u>A. C. V. D</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>65</u> , to <u>MAY 16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 12</u> , 19 <u>66</u> , and that death occurred at <u>9:00</u> A.M., from the causes and on the date stated above. 22a. SIGNATURE <u>John P. Yun</u> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>JOHN P. YUN</u> 22d. ADDRESS <u>HARFORD GRACE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>May 19 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Arlington Va.</u>		24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u> ADDRESS <u>Harford Grace Md</u> 25a. REC'D BY REGISTRAR <u>MAY 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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may 18 1966

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BEL AIR		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BEL AIR	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 120 MAULSBY AVE		d. STREET ADDRESS 120 MAULSBY AVE	
3. NAME OF DECEASED (Type or print) ARCHER AVRES		4. DATE OF DEATH May 10 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 31-1980
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR: Months 12 Days 1 IF UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY STATE ROAD	
11. BIRTHPLACE (County & State, or foreign country) ROCKS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES AVRES		14. MOTHER'S MAIDEN NAME LARA HARMON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 312-22-3196	
17. INFORMANT ANNIE B. AVRES		120 Address MAULSBY AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CV Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-1 , 19 63 , to 5-10 , 19 66 , that (I) (we) last saw the deceased alive on 5-2 , 19 66 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Gerald C Palmer		22b. DATE SIGNED 5-10-66	
22c. PHYSICIAN'S NAME (Type) Gerald C Palmer		22d. ADDRESS Bel Air, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/12/1966	
23c. NAME OF CEMETERY OR CREMATORY WILLIAM WATTERS		23d. LOCATION (City, town or county) (State) COOPTOWN MARYLAND	
24. FUNERAL DIRECTOR Charles E. Kutz		25a. REC'D BY REGISTRAR MAY 11 1966	
ADDRESS Jarrettsville, Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

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May 10

Arteriosclerotic CV Disease



1-1 10 8-10

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Gerold E Palmer

2-11-10
Berg A. M.

MAY 11 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06978

CERTIFICATE OF DEATH

06969

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen PG, Md. c. LENGTH OF STAY IN 1b 5 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kirk Army Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen d. STREET ADDRESS 218 Edmund St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Regina Middle Agnes Last Bahel		4. DATE OF DEATH Month May Day 9 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Nov 1884
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles B. Miller		14. MOTHER'S MAIDEN NAME Leah J. Cloman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-54-7708 T	
17. INFORMANT Mrs. Margaret M. Hartig,		Address 214 Edmund St. Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) THE DOCTOR attended the deceased from 4 May , 19 66 , to 9 May , 19 66 , that (I) WE last saw the deceased alive on 9 May , 19 66 , and that death occurred at 1220M , from the causes and on the date stated above.			
22a. SIGNATURE Harold C. Sheaffer		22b. DATE SIGNED 9 May 1966	
22c. PHYSICIAN'S NAME (Type) HAROLD C. SHEAFFER, Capt., MC		22d. ADDRESS Kirk Army Hospital, Aberdeen PG, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12 May 66	
23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens, Aberdeen, Maryland		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Walter W. Wacouch Jr.		25a. REC'D BY REGISTRAR MAY 12 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Handwritten signature

MAY 13 1966

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06979					06970				
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Ma</u> b. COUNTY <u>Harford</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>			c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>66 Harford Memorial Hospital</u>					d. STREET ADDRESS <u>RFD 1</u>				
3. NAME OF DECEASED (Type or print) <u>Sarah Elizabeth Baker</u>			4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1966</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 June 1884</u>		9. AGE (In years last birthday) <u>81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford County, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jackson B. Flowers</u>					14. MOTHER'S MAIDEN NAME <u>Lydia Fantom</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-12-4063-A</u>		17. INFORMANT <u>John T. Baker, Aberdeen, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221 Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CV Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>5-26</u> , 19 <u>66</u> to <u>5-30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-30</u> 19 <u>66</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Ralph Horky</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/31/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>J. Ralph Horky, MD</u>					22d. ADDRESS <u>Churchville, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2 June 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air, Maryland</u>			
24. FUNERAL DIRECTOR <u>John G. Tarring</u>					25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

05372

05372

18 June 1966

Harford County, Md. U.S.A.

Lydia Hanson

James B. Flower

John T. Baker, Aberdeen, Md.

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JUN 2 1966
JUN 2 1966
JUN 2 1966

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06971

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Proving Ground</u> c. LENGTH OF STAY IN b. <u>13 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kirk Army Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u> d. STREET ADDRESS <u>Rt. 1 Box 106-B</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Lewis</u> <u>Edward</u> <u>Bennett</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1966</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 May 06</u>		9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Guard</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US Army</u>				11. BIRTHPLACE (County & State, or foreign country) <u>New York, Corinth</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Bennett</u>						14. MOTHER'S MAIDEN NAME <u>Mar - Mae</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>20 years service 058302890</u>				16. SOCIAL SECURITY NO. <u>058302890</u>				17. INFORMANT <u>Mildred D. Bennett</u> <u>Boy 106 B.</u> <u>Wife</u> <u>Darlington, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> 13 days													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>8 AM</u> , 19 <u>66</u> , to <u>2:12 PM</u> , 19 <u>66</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>21 May</u> , 19 <u>66</u> , and that death occurred at <u> </u> M., from the causes and on the date stated above.													
22a. SIGNATURE <u>Peter Giustra</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>21 May 66</u>							
22c. PHYSICIAN'S NAME (Type) <u>PETER GIUSTRA, CAPT., MC</u>						22d. ADDRESS <u>KAH, APG, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/27/66</u>				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY <u>Darlington Md.</u>				23d. LOCATION (City, town or county) <u>Darlington Va.</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Lee</u>						ADDRESS <u>Harold Lee</u>						25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08937

CENTINELA EL GRATO

08938

Barford

Thomas Brown

11 Ave

London

High New Hospital

Box 100-H

Yale

Box 100

Thomas Brown

Box 100

Robert

Thomas

Box 100

Box 100

WILLIAM BROWN, JR.

Box 100

8/1/60

Box 100

Handwritten notes and signatures at the bottom left.

FOR STATE
HEALTH DEPT.

06981

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06972

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Immel Brook Road</u>		d. STREET ADDRESS <u>RD</u>	
3. NAME OF DECEASED (Type or print) <u>Walter</u> First Middle Last		4. DATE OF DEATH <u>May 18</u> 19 <u>66</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-15</u> 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Local 96</u>	9. AGE (In years last birthday) <u>50</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter R. Bond</u>		14. MOTHER'S MAIDEN NAME <u>Christine Bay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-0708949</u>	
17. INFORMANT <u>Mrs Ethel Bond Harford Road Hyde, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		Address (Street, city, town, or county) <u>Bel Air, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5-21-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Md.</u>
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Bel Air Road</u>		25. REC'D BY REGISTRAR <u>(36)</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 23 1966</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Of course along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1802

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06982

06973

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground				c. LENGTH OF STAY IN ID 1 day			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Infant Male Middle Burroughs Last Burroughs				4. DATE OF DEATH Month May Day 31 Year 1966			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 May 66		9. AGE (In years last birthday) yrs. 12 Months 1 Days 2 Hours 2 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Harford, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wardell Burroughs				14. MOTHER'S MAIDEN NAME Thompson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Barbara Burroughs Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1703 31 May 1966 , to 1905 31 May 1966 that (I) (we) last saw the deceased alive on 31 May 1966 , and that death occurred at 1905 M , from the causes and on the date stated above.							
22a. SIGNATURE Bradley T Barnes - Captain				22b. DATE SIGNED 31 May 66		22c. PHYSICIAN'S NAME (Type) BRADLEY T BARNES Capt, MC	
22d. ADDRESS Kirk Army Hospital APG, Md				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/2/1966		23c. NAME OF CEMETERY OR CREMATORY APG Post Cemetery		23d. LOCATION (City, town or county) (State) Aberdeen Proving Ground Md.	
24. FUNERAL DIRECTOR W. A. Thomas Jr., Perryville, Md.				25a. REC'D BY REGISTRAR JUN 6 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06983

CERTIFICATE OF DEATH

06974

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen			
c. LENGTH OF STAY IN 1b 1 Day				d. STREET ADDRESS 320 So. Philadelphia Ave. Blvd.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kirk Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Rex Allen CATRON				4. DATE OF DEATH Month May Day 3 Year 19 66			
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 May 66	
9. AGE (In years last birthday) 12		IF UNDER 1 YEAR Months 12 Days 36		IF UNDER 24 HRS. Hours 12 Min. 36			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Aberdeen Proving Gr., Md.	
12. CITIZEN OF WHAT COUNTRY USA							
13. FATHER'S NAME Danny H. CATRON				14. MOTHER'S MAIDEN NAME Debbie KEESYMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. N/A		17. INFORMANT Father, same as 2 C & D	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (b) } (c) DUE TO (e), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH From birth			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3 May 1966 , to 3 May 1966 that (I) (we) last saw the deceased alive on 3 May 1966 , and that death occurred at 6:15 PM from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i> M.D.				22b. DATE SIGNED 3 May 66			
22c. PHYSICIAN'S NAME (Type) Aberdeen Proving Ground, Md.				22d. ADDRESS Aberdeen Proving Ground, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6 May 66		23c. NAME OF CEMETERY OR CREMATORY A.P.G. Post Cemetery		23d. LOCATION (City, town or county) (State) Aberdeen Proving Ground	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> Tarring Funeral Home				25a. REC'D BY REGISTRAR MAY 9 1966			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CENTRAL OF DAY

1970

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06984											
06975											
1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural) c. LENGTH OF STAY IN 1b 12-1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route #1						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural) d. STREET ADDRESS Route #1, Box 151-A e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Blanche May Curry First Middle Last						4. DATE OF DEATH May 13 1966 Month Day Year					
5. SEX Female		6. COLOR OR RACE Cau.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 July 1889		9. AGE (In years last birthday) 76 yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Harford County, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert F. Cullum						14. MOTHER'S MAIDEN NAME Maggie May Homer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. 218-01-2310		17. INFORMANT LeRoy Cullum, Same as 2 C & D. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x DUE TO Acromyosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary tract infection INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs. 10 yr.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1953 to 5-13-1966 , that (I) (we) last saw the deceased alive on 5-13-1966 , and that death occurred at 12:00 PM from the causes and on the date stated above.											
22a. SIGNATURE P. P. Rodman						22b. DATE SIGNED 5-13-66					
22c. PHYSICIAN'S NAME (Type) P. P. Rodman						22d. ADDRESS Aberdeen Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 15 May 66		23c. NAME OF CEMETERY OR CREMATORY Wesleyan Chapel Cemetery, Aberdeen, Maryland			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR Wesleyan Chapel Home Aberdeen, Maryland						25a. REC'D BY REGISTRAR MAY 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06976									
1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Grace</i>					c. LENGTH OF STAY IN 1b <i>8 weeks</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Forest Hill</i> <i>12-1</i>				
d. STREET ADDRESS <i>Route #1 Box 49</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>Nannie</i> Middle <i>Mae</i> Last <i>Eller</i>					4. DATE OF DEATH Month <i>MAY</i> Day <i>14</i> Year <i>1966</i>				
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 13, 1917</i>		9. AGE (in years last birthday) <i>49</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Clover, S.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>					14. MOTHER'S MAIDEN NAME <i>Unknown</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <i>216-38-4274</i>		17. INFORMANT <i>Grant A. Eller, Forest Hill, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Cardiac Deкомпensation</i> <i>416X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Old rheumatic heart disease</i> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>March 20, 1966</i> to <i>May 14, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 14, 1966</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>Edward C. Loo</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/15/66</i>		
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>					22d. ADDRESS <i>Harford Grace, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>May 17, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Gardens</i>		23d. LOCATION (City, town or county) (State) <i>Bel Air, Harford Md.</i>		
24. FUNERAL DIRECTOR <i>Howard K. McComas & Son, Abingdon, Md.</i>					25a. REC'D BY REGISTRAR <i>MAY 18 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

0523

0523

Chronic Bronchitis
Chronic Bronchitis

Report of
Examination
of
the
patient
on
the
11th
of
May
1966

MAY 18 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06986

CERTIFICATE OF DEATH

06977

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u> 12-1	
c. LENGTH OF STAY IN 1b <u>6 1/2 hrs.</u>		d. STREET ADDRESS <u>366 CONGRESS AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HORACE</u> First Middle Last <u>FAIRFIELD</u>		4. DATE OF DEATH <u>MAY</u> Month Day Year <u>27</u> <u>19</u> <u>66</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8/9/1916</u> 9. AGE (In years last birthday) <u>49</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard O. Fairfield</u>		14. MOTHER'S MAIDEN NAME <u>Callie Hultz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Thelma F. Billings</u> Address <u>366 Congress</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac dilatation</u> 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary edema</u> DUE TO (c) <u>1 day</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 27, 1966</u> , 19 <u>66</u> to <u>May 27, 1966</u> that (I) (we) last saw the deceased alive on <u>May 27, 1966</u> , and that death occurred at <u>3:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Wm. H. Wucloston</u> M.D.		22b. DATE SIGNED <u>5/27/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>5/31/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bristol</u>	23d. LOCATION (City or Town) (County) (State) <u>Bristol Ind.</u>
24. FUNERAL DIRECTOR <u>Wm. H. Wucloston, Md.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>JUN 1 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

9920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06987		06978									
1. PLACE OF DEATH a. COUNTY Harford MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground				c. LENGTH OF STAY IN 1b 4 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood, Maryland				12-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kirk Army Hospital						d. STREET ADDRESS 1340 E. Grant Ct.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
		FINSTROM, Infant Male						May		29 19 66	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 May 1966		9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months 4 Days 4 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Harford Co., Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FINSTROM, Carl G.						14. MOTHER'S MAIDEN NAME JENSEN, Joanne					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Hosp Records -				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kernicterus 7706 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Erythroblastosis fetalis OUE TO (c) Hyaline membrane disease OUE TO										INTERVAL BETWEEN ONSET AND DEATH 4 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 25 , 19 66 , to May 29 , 19 66 , that (I) (we) last saw the deceased alive on May 29 , 19 66 , and that death occurred at 10:10 PM from the causes and on the date stated above.											
22a. SIGNATURE Thomas Fraher MD								22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) THOMAS FRAHER, M.D.								22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 1, 66		23c. NAME OF CEMETERY OR CREMATORY Post Cemetery				23d. LOCATION (City, town or county) (State) Aberdeen Proving Gd. Md.			
24. FUNERAL DIRECTOR James B. Gough						25a. REC'D BY REGISTRAR JUN 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			
ADDRESS Tarring Funeral Home											
Aberdeen, Maryland											

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06988

06979

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover Road</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>S.</u> Last <u>Frommelle</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 21-1934</u>	
9. AGE (In years last birthday) <u>31</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Frommelle</u>				14. MOTHER'S MAIDEN NAME <u>Mildred E. Barrenberger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>170-26-8964</u>		17. INFORMANT <u>Phyllis Frommelle wife</u>			
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull, nose, femur</u> 8194 DUE TO <u>multiple ribs, etc bones</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>L. forearm</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto vs obj type</u>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>5:13</u> p.m. <u>19 66</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Mountain Rd</u>	
20f. (City or town) <u>Fallston</u>		20g. (County) <u>Harford</u>		20h. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald P Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bol Air</u>			
EXAMINER'S NAME (Type) <u>Gerald P Palmer</u> M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5-14-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>May 16, '66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u>	
23d. LOCATION (City or Town) <u>Fallston</u>		23e. (County) <u>Harford</u>		23f. (State) <u>Md</u>			
24. FUNERAL DIRECTOR <u>W H Archer</u>				25a. REC'D BY REGISTRAR <u>Benson M</u>		25b. REGISTRAR'S SIGNATURE <u>J. J. Judge</u>	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR AISM (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Hayed</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havedale</u>						c. LENGTH OF STAY IN 1b <u>DOA</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DOA Hayed Municipal Center</u>						d. STREET ADDRESS <u>RD 1</u>					
3. NAME OF DECEASED (Type or print) <u>James Wade Gibson</u>						4. DATE OF DEATH <u>May 8 1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 12, 1946</u>		9. AGE (in years last birthday) <u>19</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Company</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George C. Gibson</u>						14. MOTHER'S MAIDEN NAME <u>Faye Hawley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>213-46-0946</u>		17. INFORMANT Address <u>Mr. Geo. Gibson, Rising Sun, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 8254 DUE TO <u>Pushing Injury Chest</u> (b) DUE TO <u>Fracture L femur</u> (c) <u>Fracture L femur</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident</u>					
20c. TIME OF INJURY Month, Day, Year <u>11 5-8-66</u> Hour <u>5:40</u> p.m.						20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>ns 40</u>		20f. (City or town) (County) (State) <u>Perryville Cecil Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Gerald C. Palmer</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Gerald C. Palmer</u>						22. DATE SIGNED <u>5-9-66</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>May 11, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>North East, Md.</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son</u> ADDRESS <u>Perryville, Md.</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
MAY 17 1966											

02930

Volume 4, 1941

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06990

06981

1. PLACE OF DEATH a. COUNTY <u>Harford</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Home de Lane</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Naval Hospital</u>				d. STREET ADDRESS <u></u>			
3. NAME OF DECEASED (Type or print) <u>John Dawson</u> First <u>Dawson</u> Middle <u>Gilman</u> Last <u>Gilman</u>				4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1946</u>	9. AGE (In years last birthday) <u>19</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter's Assist.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dawson S. Gilman</u>				14. MOTHER'S MAIDEN NAME <u>Frances J. Poole</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. Linda D. Gilman, Perryville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 8254 DUE TO <u>Crushing injury R. chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Auto Accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>5-8</u> p.m. <u>66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HS 40</u>		20f. (City or town) (County) (State) <u>Perryville Cecil Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		22. DATE SIGNED <u>5-9-66</u>					
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		22. DATE SIGNED <u>5-9-66</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Principio Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Principio Furnace Md</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson</u>		ADDRESS <u>Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1881

My dear Sir,
I have the pleasure to
acknowledge the receipt of
your letter of the 14th inst.
and in reply to inform you
that the same has been
forwarded to the proper
authorities for their
consideration.

Yours faithfully,
J. H. [Signature]

A. H. [Signature]

1881

Respectfully,
C. H. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06991

CERTIFICATE OF DEATH

06982

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford-Grace</u>		c. LENGTH OF STAY IN lb <u>26 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>R.F.D. Box 334</u>	
3. NAME OF DECEASED (Type or print) <u>Cora Mitchell Gorrell</u>		4. DATE OF DEATH Month <u>5</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1894</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>27</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public school</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Alexander Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Deh Lia Chesney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-16-0383</u>	
17. INFORMANT <u>Herbert M. Gorrell (Husband)</u>		Address <u>(Husband)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, anterior</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary thrombosis descending</u> DUE TO <u>Coronary</u> (c) <u>Arteriosclerotic cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-27, 1966</u> to <u>5-27, 1966</u> , that (I) (we) last saw the deceased alive on <u>5/27</u> 19 <u>66</u> , and that death occurred at <u>3 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard J. Colfer</u>		22b. DATE SIGNED <u>5/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard J. Colfer</u>		22d. ADDRESS <u>Harford Memorial Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 30, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Methodist Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Bel Air Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		25a. REC'D BY REGISTRAR <u>JUN 1 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06992					06983						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY		Harford			a. STATE		Md				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Harford			b. COUNTY		Harford				
c. LENGTH OF STAY IN 1b		8 days			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Forest Hill				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Harford Memorial			d. STREET ADDRESS		Jarrettville Rd				
3. NAME OF DECEASED (Type or print)		First Middle Last			4. DATE OF DEATH		Month Day Year				
5. SEX		F			8. DATE OF BIRTH		9. AGE (In years last birthday)				
6. COLOR OR RACE		W			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. OATE OF BIRTH		11. IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife			10b. KIND OF BUSINESS OR INDUSTRY		Homemaker		11. BIRTHPLACE (County & State, or foreign country)		
13. FATHER'S NAME		John Mumford			14. MOTHER'S MAIDEN NAME		Maria Mumford			12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		NO			16. SOCIAL SECURITY NO.		213-52-5841		17. INFORMANT (Daughter) 692-6119 Address Mrs. Edna G. Hullcoat Forest Hill, Md. 21050		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralytic ileus											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mesenteric thrombosis											
(c) A.S.C.V.D. Advanced											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abdominal aortic aneurysm											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from April 20, 1966 to May 3, 1966, that (I) (we) last saw the deceased alive on May 3rd, 1966, and that death occurred at 10 PM, from the causes and on the date stated above.											
22a. SIGNATURE Edward C. Loo, M.D.											
22b. DATE SIGNED 5/3/66											
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.											
22d. ADDRESS Harve de Grace, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF May 8, 1966											
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery											
23d. LOCATION (City, town or county) (State) Brewer, Penobscot Co, Maine											
24. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams St Bel Air, Maryland 21014											
25a. REC'D BY REGISTRAR MAY 6 1966											
25b. REGISTRAR'S SIGNATURE Charles Judge											

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 is to be retained by the hospital or attending physician. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
06993															
06984															
1. PLACE OF DEATH a. COUNTY <i>Md HARFORD COUNTY</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural - Abingdon</i> c. LENGTH OF STAY IN 1b <i>2 1/2 years</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>621 Long Bar Harbor Road</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Harford</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Abingdon</i> d. STREET ADDRESS <i>621 Long Bar Harbor Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>Wilton Lee Grant</i>				4. DATE OF DEATH <i>May 6 1966</i>				5. SEX <i>MALE</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>May 20, 1901</i> 9. AGE (In years, last birthday) <i>64 yrs.</i> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dairy Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Harford Co., Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William L. Grant</i>				14. MOTHER'S MAIDEN NAME <i>Theresa M. Wiker</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <i>213-26-5142</i>			
17. INFORMANT (with) <i>676-1360</i> Address <i>621 Long Bar Harbor Road Abingdon, Maryland 21009</i>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>DUE TO</i> (c) <i>DUE TO</i>				INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1-1</i> , 19 <i>38</i> to <i>5-6</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5-1</i> , 19 <i>66</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above.															
22a. SIGNATURE <i>Gerald C Palmer</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <i>5-6-66</i>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <i>Gerald C Palmer MD</i>				22d. ADDRESS <i>Bel Air, MD</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>May 9, 1966</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Methodist Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Fountain Green, Harford Co., Maryland</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph William Foster</i> ADDRESS <i>W. Broadway & Williams Sts Bel Air, Maryland 21014</i>				25a. REC'D BY REGISTRAR <i>MAY 9 1966</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

Joseph William Foster

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06994

CERTIFICATE OF DEATH

06985

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hayre de Grace				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural 07-2			
c. LENGTH OF STAY IN 1b 30 Min.				d. STREET ADDRESS Rising Sun			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Worth Middle Franklin Last Greer				4. DATE OF DEATH Month May Day 1 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5--1923	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months 42 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Construction Co. R. M. Willis			10b. KIND OF BUSINESS OR INDUSTRY Co. Lancing N. C.		11. BIRTHPLACE (County & State, or foreign country) U.S. A.		
12. CITIZEN OF WHAT COUNTRY? U.S. A.			13. FATHER'S NAME Elsie K. Greer				
14. MOTHER'S MAIDEN NAME Florence Goss			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				
16. SOCIAL SECURITY NO. 244-30-9227			17. INFORMANT Mrs. Worth Greer Address Rising Sun, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Branchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema (c) Bronchial asthma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-1 , 19 66 , to 5-1 , 19 66 , that (I) (we) last saw the deceased alive on 5-1 , 19 66 , and that death occurred at 8:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE Neil R. Taylor Jr.				22b. DATE SIGNED 5-2-66			
22c. PHYSICIAN'S NAME (Type) Neil R. Taylor Jr.				22d. ADDRESS Rising Sun, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-5-1966		23c. NAME OF CEMETERY OR CREMATORY Holiest Church Cem.		23d. LOCATION (City, town or county) (State) Yadkinville N.C.	
24. FUNERAL DIRECTOR James E. McHullen				25a. REC'D BY REGISTRAR MAY 4 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge							

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CERTIFICATE OF DEATH

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06986

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Darlington		c. LENGTH OF STAY IN 1b 86 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.#2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETTA WINIFRED HARKINS		4. DATE OF DEATH Month May Day 6 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1879
9. AGE (In years last birthday) yrs. 86		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Darlington, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin H. Klair		14. MOTHER'S MAIDEN NAME Sally B. Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Charles Ceska, Jr.		Address Ellicott City, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) Chr. arterio-sclerotic cardio-vascular disease			INTERVAL BETWEEN ONSET AND DEATH 30 Min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 25, 1947 , to May 6, 1966 that (I) (we) last saw the deceased alive on May 3, 1966 , and that death occurred at 8 p.m. from causes on and on the date stated above.			
22a. SIGNATURE Willard P. Hudson M.D.		22b. DATE SIGNED May 7, 1966	
22c. PHYSICIAN'S NAME (Type) Willard P. Hudson M.D.		22d. ADDRESS Forest Hill, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 9, 1966	23c. NAME OF CEMETERY OR CREMATORY Darlington	23d. LOCATION (City or Town) (County) (State) Darlington, Md.
24. FUNERAL DIRECTOR John H. Harkins		ADDRESS Delta, Penna.	25a. REC'D BY REGISTRAR MAY 11 1966
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items #8 & 16 Film #G377, 5/2/66 pc														
06996					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					06987				
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 03-2									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woods-near Joppa Md.					d. STREET ADDRESS 18 Dihedral Dr.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Thomas C. Hilderbrand					4. DATE OF DEATH Month Day Year 5 30 19 66									
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1911		9. AGE (In years lost birthday) 54 yrs.		10. IF UNOER 1 Year Months Days Hours Min.				
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Dice-Seller Ben's Corp.					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick, Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Jacob John Hilderbrand					14. MOTHER'S MAIDEN NAME FANNIE FAGAN									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 214-10-2217		17. INFORMANT Mrs. Helen K. Hilderbrand			Address 4111 White Ave BALT. MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) inhalation of exhaust fumes											
20c. TIME OF INJURY Month, Day, Year Hour 12:50 p.m. 5 30 19 66			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) woods			20f. (City or town) (County) (State) Joppa Harford Md.						
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Werner U. Spitz M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 5/31/66						
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF 6-3-66		23c. NAME OF CEMETERY OR CREMATORY Union Chapel Cemetery			23d. LOCATION (City or Town) (County) (State) Frederick Co. Md.				
24. FUNERAL DIRECTOR Robert E. Bailey Jr.					ADDRESS Frederick, Md.			25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge				
DATE JUN 1 1966														

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06997

CERTIFICATE OF DEATH

06988

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN lb <u>33 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> 12-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Box 150</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>STEVENSON</u> Middle <u>S.</u> Last <u>Hoffman</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1906</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Hoffman</u>				14. MOTHER'S MAIDEN NAME <u>Andora Wildason</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-01-0999</u>		17. INFORMANT (Wife) <u>Mr. 2-2375</u> Address <u>Mrs. Burnice B. Hoffman</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma foris</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>gastine carcinoma</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>4 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 25, 1966</u> to <u>May 26, 1966</u> that (I) (we) last saw the deceased alive on <u>May 26, 1966</u> , and that death occurred at <u>3:30</u> M, from causes on the date stated above.							
22a. SIGNATURE <u>B. J. Plunkett, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. J. Plunkett, Jr., M.D.</u>				22d. ADDRESS <u>Bel Air, 617 W. Bel Air Ave., Aberdeen, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 31, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Harford Co., Maryland</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>				ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR <u>MAY 31 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be removed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
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1. PLACE OF DEATH a. CDUNTY <u>HARFORD</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRE de GRACE</u>						c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> 12-1					
d. NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARford Memorial Hospital</u>						d. STREET ADDRESS <u>104 Post Rd.</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Emory</u> Middle <u>Lee</u> Last <u>Howlett</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. CDLDR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 20, 1898</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor of Labor Dept.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired A.P.G.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MO.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>George Henry Howlett</u>						14. MOTHER'S MAIDEN NAME <u>MARY ANN REED</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>G. RICHARD HOWLETT</u> Address <u>105 N. 33rd St., P.O. ABERDEEN, MO.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure - Congestion</u> 1533 DUE TO (b) <u>Carcinoma toxic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Significant Carcinoma</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4-5 weeks</u> <u>4-5 mos</u> <u>6 mos +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 28, 1966</u> , to <u>2 May, 1966</u> , that (I) (we) last saw the deceased alive on <u>2 May, 1966</u> , and that death occurred at <u>8A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles J. Foley Jr.</u>										22b. DATE SIGNED <u>5/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES J. FOLEY JR.</u>						22d. ADDRESS <u>400 S. UNION AVE H. DE G. Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>MAY 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESLEYAN CHAPEL CEM.</u>			23d. LOCATION (City, town or county) (State) <u>HARFORD CO. MO</u>			
24. FUNERAL DIRECTOR <u>R. Madison Mitchell, Harre de Grace Md.</u>						25a. REC'D BY REGISTRAR <u>MAY 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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06990

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Rt. 1 Box 180</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Isennock</u>		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1966</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) yrs. <u>2</u> Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Harford Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick B. Isennock</u>		14. MOTHER'S MAIDEN NAME <u>Alberta L. Lloyd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Fredrick B. Isennock, Rt. 1, Box 180, Rocks,</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 7699 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory distress syndrome</u> (c) <u>Prematurity</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Maternal influenza</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-4</u> , 19 <u>66</u> , to <u>5-6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-6</u> 19 <u>66</u> , and that death occurred at <u>10 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard Norment</u>		22b. DATE SIGNED <u>5-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard Norment, M.D.</u>		22d. ADDRESS <u>602 S. Union Ave., Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 9, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BelAir Memorial Gardens</u>	23d. LOCATION (City, town or county) (State) <u>BelAir Harford Md</u>
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 10 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Handwritten notes and markings, including a large 'X' and various illegible characters.

MAY 10 1950

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07000

06991

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Convalescing Home</u>				d. STREET ADDRESS <u>222 Washington St</u>			
3. NAME OF DECEASED (Type or print) <u>Emily C James</u>				4. DATE OF DEATH <u>May 6</u> 19 <u>66</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>4-7-195</u>		9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR: Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Harford, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph A Cunningham</u>				14. MOTHER'S MAIDEN NAME <u>Bedeliah Hollahan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Cunningham</u>		17. INFORMANT <u>M.R. Cunningham</u> Address <u>229 Washington St Harford Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture L. femur</u> 9040 DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u>Arteriosclerotic CV Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> p.m. <u>4-27</u> 19 <u>66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Harford Md Harford Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				address (Street, city, town, or county) <u>Bel Air, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5/9/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Harford Md Harford Md</u>	
24. FUNERAL DIRECTOR <u>Cunningham</u>				25a. REC'D BY REGISTRAR <u>May 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07001

06992

1. PLACE OF DEATH a. COUNTY <u>HARford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE D.C.A.</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>				e. STREET ADDRESS <u>614 Lewis St.</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Gough</u> Last <u>JARMAN</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>11</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 19 1898</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mp.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WM. F. JARMAN</u>				14. MOTHER'S MAIDEN NAME <u>MARY GOUGH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>216-14-2080</u>		17. INFORMANT <u>HAZEL S. JARMAN, 614 Address LEWIS ST. HAURE DE GRACE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 11</u> , 19 <u>66</u> , to <u>May 11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 11</u> , 19 <u>66</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward S. Simon</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. SIMON</u>				22d. ADDRESS <u>Haure de Grace, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>May 14, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM</u>		23d. LOCATION (City, town or county) (State) <u>HAURE DE GRACE MD</u>	
24. FUNERAL DIRECTOR <u>R. Madison MITCHELL</u>				ADDRESS <u>HAURE DE GRACE MD</u>		25a. REC'D BY REGISTRAR <u>May 17 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please file the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

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07002

CERTIFICATE OF DEATH

06993

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN lb <u>3 1/2 days</u>	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>Bay Rd - Green Acres</u>	
3. NAME OF DECEASED (Type or print) <u>Charlotte</u> First <u>J.</u> Middle <u>S.</u> Last <u>Jones</u>		4. DATE OF DEATH <u>May 24</u> Month <u>May</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1924</u> 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>York Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB HENRY</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET BARBEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-12-8799A</u>	
17. INFORMANT <u>Mrs. Elsie Cheek</u>		Address <u>Whiteford, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-21</u> , 19 <u>66</u> to <u>5-24</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>5-24</u> 19 <u>66</u> , and that death occurred on <u>5-24</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>George T. Stanbury</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>5/24/66</u>
22c. PHYSICIAN'S NAME (Type) <u>George T. Stanbury</u>		22d. ADDRESS <u>569 Revolution St. Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>May 26, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>	23d. LOCATION (City or Town) (County) (State) <u>DELTA, PA.</u>
24. FUNERAL DIRECTOR <u>John H. Harbison</u>		ADDRESS <u>DELTA, PA.</u>	25a. REC'D BY REGISTRAR <u>MAY 25 1966</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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Name of Deceased		Date of Birth	
Sex		Race	
Place of Birth		Date of Death	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Entry		Date of Filing	
Signature of Deceased		Signature of Next of Kin	
Signature of Burial Officer		Signature of Undertaker	
Signature of Coroner		Signature of Medical Examiner	
Signature of Police Officer		Signature of Sheriff	
Signature of Judge		Signature of Clerk	
Signature of Mayor		Signature of Councilman	
Signature of Minister		Signature of Priest	
Signature of Rabbi		Signature of Imam	
Signature of Other		Signature of Other	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
07003					CERTIFICATE OF DEATH					06994									
1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Have de Grace</i>					c. LENGTH OF STAY IN 1b <i>Lifetime</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Have de Grace</i>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>825 Juanita Street</i>					d. STREET ADDRESS <i>825 Juanita Street</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <i>Maggie</i> Middle <i>L.</i> Last <i>Kenly</i>					4. DATE OF DEATH Month <i>5</i> Day <i>19</i> Year <i>1966</i>														
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 16, 1888</i>		9. AGE (In years last birthday) <i>77</i> yrs. Months <i>10</i> Days <i>3</i>		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Private Family</i>					11. BIRTHPLACE (County & State, or foreign country) <i>Aberdeen, Maryland</i>					12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				
13. FATHER'S NAME <i>John Kenly</i>					14. MOTHER'S MAIDEN NAME <i>Annie Williams</i>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>none</i>					17. INFORMANT Address <i>Mrs. Ellen Cooper, Abingdon, Md.</i>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Cerebral Thrombosis - Left Hemiplegia</i> DUE TO (c) <i>Hypertensive Cardiovascular Disease</i>										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>9/15</i> , 19 <i>60</i> , to <i>5/19</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5/17</i> , 19 <i>66</i> , and that death occurred at <i>2:30</i> AM, from the causes and on the date stated above.										22a. SIGNATURE <i>George T. Stansbury</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <i>5/21/66</i>				
22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>					22d. ADDRESS <i>569 Revolution St. Harford, Md.</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					23b. DATE THEREOF <i>5-21-66</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem. Aberdeen, Harford Co. Md.</i>					23d. LOCATION (City, town or county) (State)				
24. FUNERAL DIRECTOR <i>Otelia J. Bullock, Have de Grace, Md.</i>					ADDRESS <i>556 Lewis St.</i>					25a. REC'D BY REGISTRAR <i>MAY 23 1966</i>					25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07004

06995

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		d. STREET ADDRESS <u>53 E Bel Air Ave Apt 8</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine Henrietta Langewisch</u>		4. DATE OF DEATH <u>5 14 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 Oct. 1887</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. FATHER'S NAME <u>Louis Lang</u>		15. MOTHER'S MAIDEN NAME <u>Elizabeth Peters</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>	
18. INFORMANT <u>Vivian Langewisch, same as 2 C & D</u>		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic Ulcerative Colitis</u> 5722 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>DUE TO</u> (c) <u>DUE TO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/3/66</u> , 19 <u>66</u> to <u>5/14/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/14/66</u> , 19 <u>66</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.		22a. SIGNATURE <u>Dr. Grigoleit</u>	
22b. DATE SIGNED <u>5/14/66</u>		22c. PHYSICIAN'S NAME (Type) <u>A.W. GRIGOLEIT</u>	
22d. ADDRESS <u>Havre de Grace, Md.</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>16 May 66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>The Evergeens Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Brooklyn, New York</u>	
24. FUNERAL DIRECTOR <u>John A. Tarring</u>		25a. REC'D BY REGISTRAR <u>MAY 17 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>Aberdeen, Maryland</u>	

28382

28382

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Handwritten notes and signatures in the middle section of the page, including a signature that appears to read "John F. Kennedy".

Handwritten notes and signatures in the lower middle section of the page, including a signature that appears to read "John F. Kennedy".

Handwritten notes and signatures at the bottom of the page, including a signature that appears to read "John F. Kennedy".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06996									
1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARVARD de GRACE			c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital					d. STREET ADDRESS Perryman Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Francis Lee			First Middle Last		4. DATE OF DEATH MAY 23 1966		Day Year		
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1905		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Car			11. BIRTHPLACE (County & State, or foreign country) Harford Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Sailor Lee					14. MOTHER'S MAIDEN NAME Sarah Kehoe				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 215-09-1560		17. INFORMANT Laura McComas Lee, Perryman, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure Following Cardiac Arrest 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Anemia (P.A.?) DUE TO (c) Hypertensive Cardiovascular Disease								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatic Insufficiency (Cirrhosis)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/18 , 1966 to 5/23 , 1966, that (I) (we) last saw the deceased alive on 5-23 1966, and that death occurred at 2:33 PM , from the causes and on the date stated above.									
22a. SIGNATURE George T. Stansbury					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/23/66		
22c. PHYSICIAN'S NAME (Type) George T. Stansbury					22d. ADDRESS 569 Revolution St. Harv de Grace, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 26, 1966		23c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery		23d. LOCATION (City, town or county) (State) Perryman, Harford Co., Md.		
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.					ADDRESS		25a. REC'D BY REGISTRAR MAY 25 1966		
					25b. REGISTRAR'S SIGNATURE Charles Judge				

88003

STATE OF TEXAS

88003

MAY 2 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07006

CERTIFICATE OF DEATH

06997

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN lb <u>28 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u> <u>12-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Box 65</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Stephan</u> First <u>Christopher</u> Middle <u>Boy</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1966</u>		9. AGE (In years last birthday) yrs. <u>21</u>	IF UNDER 1 YEAR Months <u>21</u> Days <u>3</u> Hours <u>35</u>	IF UNDER 24 HRS. Hours <u>35</u> Min. <u>35</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Francis Martin</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Ann Church</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT (Father) <u>734-7219</u> Address <u>Mr. John F. Martin Churchville, Maryland 21028</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory insufficiency</u> <u>7547</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Transpiration of great vessels</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia (Aspiration)</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-24</u> , 19 <u>66</u> , to <u>5-24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-24</u> , 19 <u>66</u> , and that death occurred at <u>10:38</u> AM, from causes and on the date stated above							
22a. SIGNATURE <u>Alonso Gomez</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alonso Gomez</u>				22d. ADDRESS <u>419 S. Union Ave. Havre de Grace Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 26, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth Air Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Beth Air, Harford Co., Maryland</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>				25a. REC'D BY REGISTRAR <u>W. Brownway & Williams St</u> <u>Beth Air, Maryland 21014</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

100220

UNITED STATES OF AMERICA

80050

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07007 06998											
1. PLACE OF DEATH a. COUNTY Harford MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural) 12-1				d. STREET ADDRESS Route #3, Box 145	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route #3, Box 145						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First CHARLES Middle N. Last MCCOMMONS						4. DATE OF DEATH Month May Day 11 Year 19 66					
5. SEX Male		6. COLOR OR RACE Cau.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 April 1875 91 yrs.		9. AGE (in years last birthday) IF UNDER 1 YEAR Months Days Hours Min.		10. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drawbridge Tender				10b. KIND OF BUSINESS OR INDUSTRY Penna. R.R. (Ret)		11. BIRTHPLACE (County & State, or foreign country) Harford County, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph T. McCommons						14. MOTHER'S MAIDEN NAME Caroline Ward					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 717-07-5662		17. INFORMANT Rose McCommons, Aberdeen, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Circulatory Failure 4501 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Congestive of Left Foot PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12-26 - 1963 to 5-11 - 1966 , that (I) (we) last saw the deceased alive on 5-10 - 1966 , and that death occurred at 9:55 AM , from the causes and on the date stated above.											
22a. SIGNATURE Peter P. Rodman						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-12-66			
22c. PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.						22d. ADDRESS 8 Law St. Aberdeen, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 14 May 66		23c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery		23d. LOCATION (City, town or county) (State) Perryman, Maryland			
24. FUNERAL DIRECTOR Walter Macomber Jr.						ADDRESS Aberdeen, Maryland		25a. REC'D BY REGISTRAR MAY 16 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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Harford

Harford

Harford

Anderson (Harold)

Anderson (Harold)

Route 1, Box 125

Route 1, Box 125

Charles

Charles

Also

Also

Raybridge Tanager, E.P. (nest)

Raybridge Tanager, E.P. (nest)

Joseph T. McCosmon

Joseph T. McCosmon

717-97-5005 Area 400000000, Harford, Md.

717-97-5005 Area 400000000, Harford, Md.

717-97-5005 Area 400000000, Harford, Md.

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717-97-5005 Area 400000000, Harford, Md.

717-97-5005 Area 400000000, Harford, Md.

717-97-5005 Area 400000000, Harford, Md.

07008

CERTIFICATE OF DEATH

06999

Items 4, 21 Film G377 5/25/66 mh

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harund Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harund Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>569 Congress</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katharine Williams McCommons</u>		DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11 - 1886</u>
9. AGE (In years last birthday) <u>79</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u>	
11. IF UNDER 24 HRS. Hours <u>11</u> Min. <u>15</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Harund Chase</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Williams</u>		14. MOTHER'S MAIDEN NAME <u>Anna Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Annabelle McCommons</u>		Address <u>569 Congress St. Harund Chase Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>mild Hypertension - Cardio-Vascular</u> (a), stating the underlying cause last. (c) <u>disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-2-68</u> to <u>5-17-66</u> that (I) (we) last saw the deceased alive on <u>5-17-66</u> and that death occurred at <u>3</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Adrian D. M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)			
23b. DATE THEREOF <u>5/19/66</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>			
23d. LOCATION (City, town or county) (State) <u>Harund Chase, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Donna J. ...</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>MAY 20 1966</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MD b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford de Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS POA Harford Memorial Hospital	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clyde McMullen		4. DATE OF DEATH Month May Day 5 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Rising Sun, Md.	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph McMullen		14. MOTHER'S MAIDEN NAME Mary Alexander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 9100 IMMEDIATE CAUSE (a) Crushing injury R. chest DUE TO Fracture R. clavicle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tank slipped & car fell on him	
20c. TIME OF INJURY Month, Day, Year Hour 5-5 p.m. 5-5-66	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Port Deposit Cecil Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Gerald C Palmer MD		Address (Street, city, town, or county) Bel Air, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/8/66	23c. NAME OF CEMETERY OR CREMATORY Brookview	23d. LOCATION (City or Town) (County) (State) Rising Sun, Md.
24. FUNERAL DIRECTOR Ralph M Reed		25a. REC'D BY REGISTRAR MAY 9 1966	
ADDRESS Rising Sun, Md		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07010					07001						
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL FOREST HILL</u>			c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>			d. STREET ADDRESS <u>Jarrettsville Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Jarrettsville Road</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH Month Day Year			
		<u>Elsie</u>		<u>May</u>		<u>Nagle</u>		<u>May 5, 1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1891</u>		9. AGE (In years last birthday) <u>74 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore County, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Howard Shultz</u>					14. MOTHER'S MAIDEN NAME <u>Sally Ann Cox</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>218-01-1173</u>		17. INFORMANT <u>Willard S. Nagle</u>		Address <u>Forest Hill, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>Chr. arterio-sclerotic C.V.D. with decompensation 3 years</u>									INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>June 1936</u> to <u>May 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 4, 1966</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Willard P. Hudson</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 5, 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>					22d. ADDRESS <u>Forest Hill, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5/7/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Centre</u>		23d. LOCATION (City, town or county) (State) <u>Forest Hill, Maryland</u>				
24. FUNERAL DIRECTOR <u>Charles E. Kutz Jarrettsville, Md.</u>					25a. REC'D BY REGISTRAR <u>MAY 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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CERTIFICATE OF DEATH

07002

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN b. <u>11 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bremin Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> d. STREET ADDRESS <u>727 Ontario St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jennie Catherine</u> <u>Nelson</u> First Middle Last		4. DATE OF DEATH <u>5/13/66</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12/1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nils Persson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Nelson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Paul H. Lynch</u> Address <u>727 Ontario St., Harford Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>generalized circulatory collapse</u> 443X DUE TO (b) <u>Chronic Cardiac failure</u> (a), stating the underlying cause last. DUE TO (c) <u>arterio-sclerotic hypertensive cardiac degeneration</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 30</u> , 19 <u>66</u> , to <u>May 13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 13</u> , 19 <u>66</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward J. Simon</u> M.D.		22b. DATE SIGNED <u>5/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD J. SIMON</u>		22d. ADDRESS <u>Harford Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>5/17/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Eden</u>	23d. LOCATION (City, town or county) (State) <u>Harford Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Permyer</u> ADDRESS <u>Harford Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 20 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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[Faint, mostly illegible handwritten text, possibly a letter or document, covering the majority of the page.]

[Vertical text on the right margin, likely a stamp or administrative note.]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07012

07003

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u>			c. LENGTH OF STAY IN lb <u>18 days</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>			d. STREET ADDRESS <u>R.D.#2</u>		
3. NAME OF DECEASED (Type or print) <u>Maud Stevens Parker</u>			4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1966</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1874</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u> Hours <u>12</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>William Parker</u>		
14. MOTHER'S MAIDEN NAME <u>EMMA POROY</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>Mrs. A. F. Wakefield (cousin)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>old age + arteriosclerosis</u> DUE TO (c) <u>—</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>		20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 12, 1960</u> , to <u>MAY 8, 1966</u> , that (I) (we) last saw the deceased alive on <u>MAY 8, 1966</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Dudley Phillips M.D.</u>			22b. DATE SIGNED <u>5/9/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips M.D.</u>			22d. ADDRESS <u>DARLINGTON RD 21034</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 11, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCK RUN CEM.</u>	
23d. LOCATION (City, town or county) <u>HARFORD CO.</u>		23e. (State) <u>MD.</u>		23f. REC'D BY REGISTRAR <u>—</u>	
23g. REGISTRAR'S SIGNATURE <u>R. Madison Mitchell, Havre de Grace, Md.</u>		23h. DATE <u>MAY 12 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Marked

House of Grace

R.D. #2

Maud Stevens Parker

Female White

unemployed

William Parker

Md.

Mar. 1901

Mrs. C. F. Waterfield

FOR STATE
HEALTH DEPT

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07013

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07004

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Celery Cecil North East 7-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital				d. STREET ADDRESS R.D. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Horace Middle H. Last Petrea				4. DATE OF DEATH Month May Day 3 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1910		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Explosive Operator		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mose L. Petrea				14. MOTHER'S MAIDEN NAME Florence Furr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 238-20-5833		17. INFORMANT Carenner S. Petrea		Address R.D. 1 North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage due to severance left carotid and subclavian arteries. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 9103							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shell fragment struck him					
20c. TIME OF INJURY Hour 3 Minute 00 p.m. Mat 3 19 66		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) APG		20f. (City or town) (County) (State) APG Ha. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> Bel Air, Md.							
ACTUAL SIGNATURE Gerald C. Palmer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-4-66	
EXAMINER'S NAME (Type) Gerald C. Palmer M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/7/66		23c. NAME OF CEMETERY OR CREMATORY Cypress Creek Baptist		23d. LOCATION (City or Town) (County) (State) Garland, North Carolina	
24. FUNERAL DIRECTOR Grant Funeral Home				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Figure 1. (continued)

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Figure 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND								
07014			CERTIFICATE OF DEATH			07005		
1. PLACE OF DEATH a. COUNTY <i>Harford</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harford</i> c. LENGTH OF STAY IN 1b <i>55 min.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Harford Memorial</i>			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Edgewood</i> d. STREET ADDRESS <i>2145 Battle St.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Baby Girl</i>			4. DATE OF DEATH Month <i>5</i> Day <i>9</i> Year <i>1966</i>					
5. SEX <i>F</i>			6. COLOR OR RACE <i>C</i>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <i>5-9-66</i>			9. AGE (In years last birthday) <i>55</i>			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Md-USA</i>		
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Edgar Layton</i>			14. MOTHER'S MAIDEN NAME <i>Diane Pugh</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>none</i>			17. INFORMANT <i>Lucy Pugh, 2145 Battle St., Edgewood, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>776X</i> DUE TO <i>Splenic torsion.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying causal state. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <i>May 9, 1966</i> , to <i>May 9, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 9, 1966</i> , and that death occurred at <i>5:30</i> M, from the causes and on the date stated above.			22a. SIGNATURE <i>[Signature]</i>		
22b. DATE SIGNED <i>May 9, 1966</i>			22c. PHYSICIAN'S NAME (Type) <i>Lajos I. Mezei, M.D.</i>			22d. ADDRESS <i>Havre de Grace, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>May 11, 1966</i>			23c. NAME OF CEMETERY OR CREMATORY <i>John Wesley Cemetery</i>		
23d. LOCATION (City, town or county) (State) <i>Abingdon, Harford Md.</i>			24. FUNERAL DIRECTOR <i>Howard K. McComas & Son, Abingdon, Md. 21009</i>			25a. REC'D BY REGISTRAR <i>May 13 1966</i>		
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>								

6-287724

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Page 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (See page 1 and 2) Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07015

CERTIFICATE OF DEATH

07006

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNIE</u> Harford <u>Richardson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1885</u>
9. AGE (In years lost birth day) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Smith Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Pete Lawrence</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-30-4390</u>	
17. INFORMANT <u>Mrs. Lee Suda, Box 73, Joppa, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) <u>Hypertensive Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 25, 1966</u> , to <u>MAY 25, 1966</u> that (I) (we) lost saw the deceased alive on <u>MAY 25 1966</u> , and that death occurred at <u>6 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>George T. Stansbury</u>		22b. DATE SIGNED <u>5/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		22d. ADDRESS <u>569 Revolution St. Harre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 28, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Abingdon Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		25a. REC'D BY REGISTRAR <u>MAY 31 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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REMARKS ON DEATH

04018

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07016 CERTIFICATE OF DEATH 07007

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 101 N. Philadelphia Blvd.		d. STREET ADDRESS 101 N. Philadelphia Blvd	
3. NAME OF DECEASED (Type or print) WILMER V. RILEY		4. DATE OF DEATH Month May Day 4 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Aug. 1909
9. AGE (in years last birthday) 56 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Operator		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (County & State, or foreign country) Newark, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas P. Riley		14. MOTHER'S MAIDEN NAME Lillian Agnes Shellender	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-05-6544	
17. INFORMANT Dorothy G. Riley,		Address Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 177X DUE TO (b) GENERALIZED CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) CARCINOMA OF PROSTATE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 5-3-1966 , and that death occurred at 7:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE John G. Morani		22b. DATE SIGNED 5-4-66	
22c. PHYSICIAN'S NAME (Type) JOHN G. MORANI		22d. ADDRESS 6404 N. CHARLES ST. BALTIMORE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6 May 66	
23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION (City, town or county) (State) Port Deposit, Md.	
24. FUNERAL DIRECTOR Walter Macomber Jr.		25. REC'D BY REGISTRAR MAY 9 1966	
25a. ADDRESS Aberdeen, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07017

CERTIFICATE OF DEATH

07008

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		c. LENGTH OF STAY in 1b 50 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		d. STREET ADDRESS Chestnut St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chestnut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle Robinson Last Robinson		4. DATE OF DEATH Month May Day 28 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1893
9. AGE (In years last birthday) yrs. 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	
11. BIRTHPLACE (County & State, or foreign country) Mill Green, Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph M. Robinson		14. MOTHER'S MAIDEN NAME Marcellena Scarborough	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-34-3060	
17. INFORMANT Mrs. Ethel S. Robinson, Cardiff, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 28, 1966 , to May 28, 1966 , that (I) (we) last saw the deceased alive on May 28, 1966 , and that death occurred at 4p M, from causes and on the date stated above.			
22a. SIGNATURE Josiah A. Hunt		22b. DATE SIGNED May 30, 1966	
22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt		22d. ADDRESS Delta, Penna.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 31, 1966	
23c. NAME OF CEMETERY OR CREMATORY Slateville Cemetery		23d. LOCATION (City or Town) (County) (State) Delta York Pa.	
24. FUNERAL DIRECTOR John H. Harkins		25a. REC'D BY REGISTRAR JUN 2 1966	
ADDRESS Delta, Pa.		25b. REGISTRAR'S SIGNATURE Charles Judge	

80000

STATEMENT OF DEATH

1901

Name of Deceased		John A. Robinson	
Age		45	
Sex		Male	
Race		White	
Date of Death		April 1, 1901	
Place of Death		New York City	
Cause of Death		Heart Disease	
Occupation		Teacher	
Residence		123 Main St.	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		April 5, 1901	
Place of Registration		New York City	

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07018						07009					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)					
a. COUNTY <i>Harford</i> MARYLAND						a. STATE <i>Md.</i> b. COUNTY <i>Harford</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harre-de-Grace</i>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harre-de-Grace</i>					
c. LENGTH OF STAY IN 1b <i>2 hrs 30 min</i>						d. STREET ADDRESS <i>Bayou Villa Apts.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Harford Memorial Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Marquerite Boulden Rowland</i>						4. DATE OF DEATH <i>5-19-66</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 6, 1896</i>		9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CATERING WORK</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland House</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>HARRY R. BOULDEN</i>						14. MOTHER'S MAIDEN NAME <i>Lola Fleming</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i>218-32-8277</i>					
17. INFORMANT <i>Wallace M. Rowland</i>						Address <i>Harre de Grace Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>A.S.C.V.D</i> DUE TO (c) <i></i>										INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> <i>1 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5-19, 1966</i> , to <i>5-19, 1966</i> , that (I) (we) last saw the deceased alive on <i>5-19, 1966</i> , and that death occurred at <i>4:30</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>John D. Yun</i>						22b. DATE SIGNED <i>5/19/66</i>					
22c. PHYSICIAN'S NAME (Type) <i>JOHN D. YUN</i>						22d. ADDRESS <i>HARRE de GRACE Md</i>					
23a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial</i>						23b. DATE THEREOF <i>May 22, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>West Nottingham Co. Coloma Md.</i>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <i>Lee A. Callahan</i>						ADDRESS <i>Seayville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 27 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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Handwritten text at the bottom of the page, including a date stamp: MAY 22 1955.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07019						CERTIFICATE OF DEATH			07010		
1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Grace</i>				c. LENGTH OF STAY IN lb <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial</i>						d. STREET ADDRESS <i>6602 Hampnett Ave</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William George Schnitker</i>						4. DATE OF DEATH Month <i>5</i> Day <i>24</i> Year <i>1966</i>					
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>January 4, 1901</i>		9. AGE (In years last birthday) yrs. <i>65</i>		IF UNDER 1 YEAR Months <i>24</i> Days <i>19</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Machinist</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Foundry</i>		11. BIRTHPLACE (County & State, or foreign country) <i>md</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Schnitker</i>						14. MOTHER'S MAIDEN NAME <i>Anna Dehler</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Mary A. Schnitker</i>				Address <i>(Same)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive pulmonary embolism</i> <i>466x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Phlebotrombosis left femoral</i> DUE TO (c) <i>acute</i>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Basenitis - Esophagitis</i>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>May 27, 1966</i> , to <i>May 27, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 24, 1966</i> , and that death occurred at <i>8 P</i> M, from causes on and on the date stated above.											
22a. SIGNATURE <i>Mr. T. D. Druce</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/24/66.</i>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/28/66.</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>			
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>						25a. REC'D BY REGISTRAR <i>MAY 27 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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[Faint, mostly illegible handwritten text, possibly a list or ledger entries]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07020					07011				
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>HARFORD</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOPPA</u>				
c. LENGTH OF STAY IN 1b <u>16 hrs</u>					d. STREET ADDRESS <u>1827 Mountain Rd</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>JONATHAN DAVID SEXTON</u>			First Middle Last		4. DATE OF DEATH <u>MAY 29 1966</u>		Month Day Year		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-28-66</u>		9. AGE (In years last birthday) <u>12-1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Thomas W. Sexton</u>				14. MOTHER'S MAIDEN NAME <u>Lucille Parks</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Thomas W. Sexton</u>		Address <u>1827 Mountain Rd., Joppa Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Unmaturity</u> <u>776 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) } DUE TO (c) }								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 28, 1966</u> , to <u>MAY 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>MAY 29 1966</u> and that death occurred at <u>8:10 A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/29/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>F. J. Hatem, M.D.</u>				22d. ADDRESS <u>602 S. Union Ave., Havre de Grace, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 31, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BelAir Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>BelAir Harford Md.</u>			
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md.</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>JUN 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

21073

21073

JUN 1 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07021

07012

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRE DE GRACE</u>	
c. LENGTH OF STAY IN ID <u>2 days</u>		d. STREET ADDRESS <u>STAR RT.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>MAY</u> Last <u>SHERMAN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 30, 1889</u>
9. AGE (In years, last birthday) <u>77</u> yrs.		10. AGE (In years, last birthday) IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Churchville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew P. Bodt</u>		14. MOTHER'S MAIDEN NAME <u>Cora L. Greenland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Walter H. Sherman Jr.</u>		Address <u>Md. Havre de Grace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 4221 DUE TO <u>Cardiovascular disease & uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive heart failure</u> DUE TO (c) <u>anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> , 19 <u>66</u> , to <u>5/21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/21</u> , 19 <u>66</u> , and that death occurred at <u>6:18</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>A. Grigoleit</u>		22b. DATE SIGNED <u>5-21-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alfred W. Grigoleit, M.D.</u>		22d. ADDRESS <u>608 S. Union Ave. Harford, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>23 May 66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Aberdeen, Maryland</u>	
24. FUNERAL DIRECTOR <u>John D. Tarring</u>		25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

6-013

6-013

Handwritten signature
Walter J. Anderson
Director

Walter J. Anderson, D.D.

Walter J. Anderson, D.D.

MAY 24 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre-de-Grace		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William D Middle Simmons Last Simmons		4. DATE OF DEATH Month 5 Day 4 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Dec. 1891
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		9b. AGE (In years last birthday) 74 yrs.	9c. IF UNDER 1 YEAR Months 74 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Store	11. BIRTHPLACE (County & State, or foreign country) N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Simmons, Henry	
14. MOTHER'S MAIDEN NAME Ellen Hanks		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 218-09-2002-A		17. INFORMANT Grace Simmons, same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 5721 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Peritonitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-30-66 , 19 66 , to 5-4 , 19 66 that (I) (we) last saw the deceased alive on 5-4 , 19 66 , and that death occurred at 429 M, from the causes and on the date stated above.			
22a. SIGNATURE William K. Brendle		22b. DATE SIGNED May 5, 1966	
22c. PHYSICIAN'S NAME (Type) William K. Brendle, M.D.		22d. ADDRESS Havre de Grace, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7 May 1966	23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery	23d. LOCATION (City, town or county) (State) Bel Air, Maryland
24. FUNERAL DIRECTOR Walter W. W. W. W.		25a. REC'D BY REGISTRAR MAY 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

BP

Hartford Hospital
 57 Franklin St.
 Hartford, Conn.
 Dec. 1901
 N.C.
 General Scott
 2100 Main St.
 Hartford, Conn.

4-30-02
 3-4-10
 William K. Wendell
 2100 Main St.
 Hartford, Conn.
 MAY 8 1902
 2100 Main St.
 Hartford, Conn.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07023		07014									
1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u> c. LENGTH OF STAY IN 1b <u>6 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Port DePOSIT, MD</u> d. STREET ADDRESS <u>07-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Infant Girl</u>			4. DATE OF DEATH <u>May 23 1966</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>Cau</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>May 23, 1966</u>			9. AGE (In years last birthday) <u>5</u> yrs. <u>5</u> months <u>5</u> days <u>5</u> hours <u>5</u> min.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Archie E. Singleton</u>			14. MOTHER'S MAIDEN NAME <u>Vickey Stobbs</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>_____</u>			17. INFORMANT <u>Hospital Records</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Premature 6 month</u> DUE TO (b) <u>_____</u> DUE TO (c) <u>_____</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>_____</u>		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <u>May 23</u> , 19 <u>66</u> , to <u>May 23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 23</u> , 19 <u>66</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above.		
22a. SIGNATURE <u>GUNTER D. HIRSCH</u>			22b. DATE SIGNED <u>5-23-66</u>			22c. PHYSICIAN'S NAME (Type) <u>GUNTER D. HIRSCH</u>			22d. ADDRESS <u>HARVE DE GRACE, MD.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>5/24/66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Principia Cemetery, Principia, Md.</u>			23d. LOCATION (City, town or county) (State) <u>Principia, Md.</u>		
24. FUNERAL DIRECTOR <u>W. A. Thompson, Jr., Perryville, Md.</u>			25a. REC'D BY REGISTRAR <u>MAY 27 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			6-207641		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07024

CERTIFICATE OF DEATH

07015

1. PLACE OF DEATH a. CDUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>				d. STREET ADDRESS <u>457c Franklin St</u>			
3. NAME OF DECEASED (Type or print) <u>Pearl Regina Skipworth</u>				4. DATE OF DEATH <u>5-7-1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7/14/1909</u>	
9. AGE (in years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kansas U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Knowles</u>				14. MOTHER'S MAIDEN NAME <u>Beda Behn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT <u>Arthur Vicary</u> Address <u>7 N. Union Ave, Harre-de-Grace Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 170X DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Breast Carcinoma - bilateral</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>2 yrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-27</u> , 19 <u>66</u> to <u>5-7</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>5/7</u> , 19 <u>66</u> and that death occurred at <u>4:30</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles J. Foley, Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES J. FOLEY, JR.</u>						22d. ADDRESS <u>HARRE-DE-GRACE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5/14/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>McPherson</u>		23d. LOCATION (City, town or county) (State) <u>McPherson Kansas</u>	
24. FUNERAL DIRECTOR <u>Runington Co.</u>				25a. REC'D BY REGISTRAR <u>May 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

1073

1073

1073 11 YAM.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
07025					07016									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY Harford					a. STATE Maryland b. COUNTY Harford									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air									
c. LENGTH OF STAY IN 1b 2 years					d. STREET ADDRESS 332 South Main Street									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 332 South Main Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last Jennie May Smith					Month Day Year May 16, 1966									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 3, 1910		9. AGE (In years last birthday) 56 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Demonstration Agent		10b. KIND OF BUSINESS OR INDUSTRY State Govt.		11. BIRTHPLACE (County & State, or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME Guy I. Swett					14. MOTHER'S MAIDEN NAME Jennie May Record									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 006-10-4398		17. INFORMANT (Attorney) 838-7375 Office & Bond St. Mr. Charles H. Reed, Jr. Bel Air, Md. 21014										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub hepatic abscess with secondary 1561 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) implications from Sarcoma of (c) Liver								INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from May 13, 1963 , to May 16, 1966 , that (I) (we) last saw the deceased alive on May 13, 1966 , and that death occurred at 7 A.M. from the causes and on the date stated above.														
22a. SIGNATURE Cesar S. Vasquez, M.D.					22b. DATE SIGNED May 15, 1966									
22c. PHYSICIAN'S NAME (Type) Cesar S. Vasquez, M.D.					22d. ADDRESS Tollgate Road, Bel Air, Maryland 21014									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 19, 1966		23c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery			23d. LOCATION (City, town or county) (State) Burlington, Vermont						
24. FUNERAL DIRECTOR Joseph William Foster					25a. REC'D BY REGISTRAR W. Broadway & Williams Bel Air, Maryland 21014					25b. REGISTRAR'S SIGNATURE Charles Judge				

Joseph William Foster

100-104000 Mr. Charles H. Reed, Jr., Tel. 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Items 8, 9 Film G377 5/25/66 mh											
07026 07017											
1. PLACE OF DEATH a. COUNTY <i>Harford</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre St. Grace</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Brevins Home</i>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Harford</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air - Rural</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Lillian</i>			First Middle Last <i>Somerville</i>			4. DATE OF DEATH Month <i>May</i> Day <i>13</i> Year <i>1966</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 17, 1897</i>		9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Hdaco.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>W. Eliza Somerville</i>						14. MOTHER'S MAIDEN NAME <i>Elizabeth Pitcock, Bel Air</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mrs. Jean McLane</i> Address <i>-</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple malignancy -</i> 1991 DUE TO <i>Sarcoma of left leg</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <i>1/13/65</i> 19 to <i>5/13</i> 1966 that (I) (we) last saw the deceased alive on <i>5/19-66</i> 19, and that death occurred at <i>11</i> M, from the causes and on the date stated above. 22a. SIGNATURE <i>[Signature]</i> M.D. 22c. PHYSICIAN'S NAME (Type) <i>A. L. LEWIS MD</i> 22d. ADDRESS <i>Harre St. Grace md</i> 22b. DATE SIGNED											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>May 15, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mountain Christian Oppa Md</i>		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wot Archer, Benson Md</i> ADDRESS <i>-</i>						25a. REC'D BY REGISTRAR <i>MAY 20 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

[Faint, illegible handwriting covering the main body of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07027					07018				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Hartford			a. STATE		Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Haver de Grace			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Aberdeen		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Hartford Memorial			d. STREET ADDRESS		136 Osborn		
3. NAME OF DECEASED (Type or print)		Lillian Elizabeth Stevens			4. DATE OF DEATH		5 15 1966		
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
♀	W	<input checked="" type="checkbox"/> MARRIED	<input type="checkbox"/> NEVER MARRIED	Feb. 5, 1889	77 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Home		Baltimore, Maryland		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Unknown				Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT			
No						2916 New York Ave. Pearl Hutchinson, Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema, acute 4201 DUE TO (b) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1.8 hours unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/14, 1966, to 5/15, 1966, that (I) (we) last saw the deceased alive on 5/15, 1966, and that death occurred at 8 P.M. from the causes and on the date stated above.									
22a. SIGNATURE A. W. Grigoleit				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/17/66			
22c. PHYSICIAN'S NAME (Type) A. W. GRIGOLEIT				22d. ADDRESS Haver de Grace, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		18 May 66		Spesutia Cemetery		Perryman, Maryland			
24. FUNERAL DIRECTOR Helen McCoubert Sr.				ADDRESS Aberdeen, Maryland		DATE MAY 20 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

Handwritten text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. Some faint words and phrases are visible, including "Baltimore", "Maryland", "May 20 1966", and "Specialty Cemetery".

FOR STATE
HEALTH DEPT.

07028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07019

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 12-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital			d. STREET ADDRESS Route #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle T. Last STOUT JR.			4. DATE OF DEATH Month May Day 4 Year 19 66		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1959	9. AGE (In years lost birthday) yrs. 7	IF UNDER 1 YEAR Months 4 Days 19 Hours 66 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John T. Stout Sr.		
14. MOTHER'S MAIDEN NAME Gladys Nelson			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. N/A			17. INFORMANT Father, Same as 2 c & d		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to Drowning 850 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off a log boat into pond			
20c. TIME OF INJURY Month, Day, Year Hour 4:00 p.m. 5-4 19 66	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Aberdeen Ha		20f. (City or town) (County) (State) md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gerald C. Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-5-66	
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Bel Air, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 6 May 1966	23c. NAME OF CEMETERY OR CREMATORY Memorial Cemetery St Petersburg, Fla.		23d. LOCATION (City or Town) (County) (State) St Petersburg, Fla.	
24. FUNERAL DIRECTOR Walter McCowan Sr.		ADDRESS Tarring Funeral Home Aberdeen, Md.		25a. REC'D BY REGISTRAR MAY 9 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1018

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W. D. 1850

John D. 1850

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
c. LENGTH OF STAY IN 1b <u>7 days</u>		d. STREET ADDRESS <u>30 Idlewild St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Andrew Suite</u>	4. DATE OF DEATH <u>5 3 1966</u>	5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>JUNE 18, 1917</u>	9. AGE (In years last birthday) <u>48</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LINEMAN (TROUBLE)</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>GAS & Electric Co.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Andrew Suite</u>		14. MOTHER'S MAIDEN NAME <u>Cora Lee Pilkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-16-0518</u>	
17. INFORMANT (Name) <u>Mrs. MAE E. Suite</u>		Address <u>30 Idlewild Street Bel Air, Maryland 21014</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 585X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Toxic Nephrosis, Electrolyte Imbalance</u> (c) <u>Post-Operative Hemorrhage</u> <u>Empyema of the gallbladder-Cholecystectomy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u> <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>1966</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Sadowsky</u>		22b. DATE SIGNED <u>5/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. H. SADOWSKY</u>		22d. ADDRESS <u>504 Lewis St. Harford, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 6, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air, Harford Co. Maryland 21014</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25. REC'D BY REGISTRAR <u>6 1966</u>	
ADDRESS <u>W. Broadway & Williams Bel Air, Maryland 21014</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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June 15, 1917

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June 15, 1917

General Electric, Inc.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07030					07021						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Harford MARYLAND					a. STATE Md b. COUNTY Harford						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood							
c. LENGTH OF STAY IN 1b 2 years				d. STREET ADDRESS 610 Aspen Lane, Edgewood Meadows							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) none				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First Robert			Middle Lewis			Last Swann		
4. DATE OF DEATH		Month May		Day 25		Year 1966					
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1927		9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturing engineer				10b. KIND OF BUSINESS OR INDUSTRY aircraft				11. BIRTHPLACE (County & State, or foreign country) Russell Co., Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert F. Swann						14. MOTHER'S MAIDEN NAME Pearl Coffee					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. 231-24-7532		17. INFORMANT Mrs. June P. Swann, 610 Aspen Lane, Edgewood					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c) OUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/14 , 1966, to 5/25 , 1966, that (I) (we) last saw the deceased alive on 5/25 , 19, and that death occurred at 1 P.M. from the causes and on the date stated above.											
22a. SIGNATURE E. Louis Kahan						22b. DATE SIGNED 5/25/66			22c. PHYSICIAN'S NAME (Type) E. Louis Kahan, M.D.,		
22d. ADDRESS Edgewood, Maryland						22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF May 25, 1966			23c. NAME OF CEMETERY OR CREMATORY Hamlett-Dobson F.H.			23d. LOCATION (City, town or county) (State) Kingsport, Sullivan Co., Tenn		
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009						25a. REC'D BY REGISTRAR MAY 26 1966			25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07037		07022	
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAURC DE GRACE D.O.A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BELAIR</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>604 LINWOOD AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IRMA</u> Middle <u>E.</u> Last <u>WESTERKAM</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-23-1908</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>CHRISTOPHER J. GOLDBECK</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA BURTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Bertha Buffing - 604 Linwood Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X Pulmonary Heart Disease -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>enlarged heart. Mitral Stenosis</u> (b) <u>regulation of grade IV failure</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>July 1, 1962</u> to <u>May 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 15, 1966</u> and that death occurred at <u>9:00</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Donald W. Mintzer</u>		22b. DATE SIGNED <u>5/11/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD W. MINTZER</u>		22d. ADDRESS <u>3609 EIERGREEN AVE BALTO 14</u>	
22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-14-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM.</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR <u>Artley Miller, 2334 Jefferson St.</u>		25a. REC'D BY REGISTRAR <u>MAY 13 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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Harford Memorial Hospital

John

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified of the death of the deceased, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
07032					07023				
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground				
c. LENGTH OF STAY IN 1b DOA -					d. STREET ADDRESS 2823 C Fairfield Ct.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kirk Army Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Michael Middle Gunnar Last Wilcut					4. DATE OF DEATH Month May Day 17 Year 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18 1966		9. AGE (In years last birthday) yrs. 1 Months 29 Days 29 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Harford, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Donald Wilcut					14. MOTHER'S MAIDEN NAME Berit Sjuls				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. N/A		17. INFORMANT Hospital Birth Certificate		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crib Death 7730 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 1				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour 10:45 a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) XXXXXX attended the deceased from 17 May , 19 66 , to 17 May , 19 66 , that (1) was saw the deceased alive on DOA 17 May 19 66 , and that death occurred at 10:45 from the causes and on the date stated above.									
22a. SIGNATURE L.W. Wight / BFB Anne Caplan					22b. DATE SIGNED 17 May 1966			22c. PHYSICIAN'S NAME (Type) LELAND W. WIGHT, CAPT., MC	
22d. ADDRESS KAH, APG, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 23 May 66		23c. NAME OF CEMETERY OR CREMATORY Post Cemetery		23d. LOCATION (City, town or county) (State) Aberdeen Proving Ground		
24. FUNERAL DIRECTOR Tarring Funeral Home					25a. REC'D BY REGISTRAR MAY 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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DEVELOPMENT OF A SHORT-TERM

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Journal of Management Education

06-07-2008

CERTIFICATE OF DEATH

07024

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Whiteford		c. LENGTH OF STAY IN lb 25 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Line Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Whiteford 12-1	
3. NAME OF DECEASED (Type or print) First JOHN Middle GRADEN Last WOLF		4. DATE OF DEATH Month May Day 29 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1902 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (County & State, or foreign country) Hampton, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Labon Wolf		14. MOTHER'S MAIDEN NAME Ettie M. Snyder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 166-12-5963	
17. INFORMANT Mrs. Lizzie M. Wolf, Whiteford, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 3324 DUE TO (b) Arterio Sclerotic Cerebral Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 66 , to May 29 , 19 66 , that (I) (we) last saw the deceased alive on May 29 , 19 66 , and that death occurred at 1:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Josiah A. Hunt		22b. DATE SIGNED May 30, 1966	
22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt M.D.		22d. ADDRESS Delta, Penna.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 1, 1966	23c. NAME OF CEMETERY OR CREMATORY Slate Ridge	23d. LOCATION (City or Town) (County) (State) Delta York Pa.
24. FUNERAL DIRECTOR John H. Hawkins		25a. REC'D BY REGISTRAR JUN 2 1966	
ADDRESS Delta, Penna.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

750

07034

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07025

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Harford</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harde Chase</i>		c. LENGTH OF STAY IN 1b <i>Highland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harde Chase</i> 12-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>712 S Union Ave</i>				d. STREET ADDRESS <i>712 S Union Ave.</i>		
3. NAME OF DECEASED (Type or print) <i>Catherine Barbey</i>		4. DATE OF DEATH Month <i>5</i> Day <i>28</i> Year <i>1966</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <i>7/26/1906</i>		9. AGE (In years last birthday) <i>59</i> yrs.		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>12</i> Hours <i>19</i> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Harde Chase, Md.</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>George H. Barbey</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Boyd.</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>unk.</i>		17. INFORMANT <i>—</i> Address <i>—</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio-sclerotic C V Disease</i> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>						INTERVAL BETWEEN ONSET AND DEATH <i>—</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>—</i>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>—</i> p.m. <i>—</i> 19 <i>66</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		
20f. (City or town) <i>—</i>		20g. (County) <i>—</i>		20h. (State) <i>—</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Leslie E. Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Boyd</i>		22. DATE SIGNED <i>5-30-66</i>		
EXAMINER'S NAME (Type) <i>Gerald C. Palmer</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <i>—</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>6/14/66</i>		23b. DATE THEREOF <i>6/14/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		
23d. LOCATION (City, town or county) <i>Harde Chase, Md.</i>		23e. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		23f. REGISTRAR'S NAME <i>Charles Judge</i>		
24. FUNERAL DIRECTOR <i>Pennington Roy</i>		ADDRESS <i>Harde Chase Md</i>		25a. REC'D BY REGISTRAR <i>JUN 1 1966</i>		

07084

ADULT & CHILDREN'S DEPARTMENT
HOSPITAL & CLINIC
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07084

FOR STATE
HEALTH BOARD

[Faint, illegible text and markings on a medical certificate form, including fields for patient information, medical history, and examiner's signature.]

[Faint, illegible text on the right margin of the form.]

07035

CERTIFICATE OF DEATH

07026

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground		c. LENGTH OF STAY IN lb -	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		d. STREET ADDRESS P.O. Box 362 Access & Old Phila Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alex (NMI) Zabor		4. DATE OF DEATH Month May Day 5 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 March 1898
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (County & State, or foreign country) Warsaw, Poland		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wpr or dates of service) 1925 Yes 1955		16. SOCIAL SECURITY NO. 310-40-1055	
17. INFORMANT Viola F. Zabor (Wife)		Address Same as 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 1992 DUE TO (b) Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) Unk			INTERVAL BETWEEN ONSET AND DEATH Unk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (myself) attended the deceased from 5 May , 19 66 , to 5 May , 19 66 , that (I) (we) last saw the deceased alive on DOA 5 May 19 66 , and that death occurred at 3:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Harold C. Sheaffer</i>		22b. DATE SIGNED 5 May 1966	
22c. PHYSICIAN'S NAME (Type) EMORY LINDER, MD		22d. ADDRESS Kirk Army Hospital, APG, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11 May 66	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.
24. FUNERAL DIRECTOR <i>Walter W. Coulter Jr.</i>		25. REC'D. BY REGISTRAR Tarring Funeral Home DATE 11 May 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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